STATE OF VERMONT
AGENCY OF HUMAN SERVICES

DCF

Department for Children and Families

B U L L E T I N NO.: 010-02P

FROM: Joseph Patrissi, Deputy Commissioner
Economic Services Division

DATE: December 18, 2009

SUBJECT: Rule Changes to Medicaid, VHAP, Premium Assistance, and Pharmacy Programs

CHANGES ADOPTED EFFECTIVE May 1, 2010

INSTRUCTIONS

___ **Maintain Manual - See instructions below.**
_X_ **Proposed Regulation - Retain bulletin and attachments until you receive Manual Maintenance Bulletin:** 010-02F
___ **Information or Instructions - Retain until**_____

MANUAL REFERENCE(S):

PROGRAM	RULE NUMBER
Medicaid	4170 4171.2 4312.8
Dr. D	5200 - 5255
VHAP	5312 5321 5324 5342 5342.1
VScript	5620
Healthy Vermonters	5710 5724
Premium Assistance	5901 5925

Overview

This bulletin proposes changes to health care program rules necessitated by:

- Vermont Act 61 (H.444, approved June 2, 2009) entitled, *An Act Related to Health Care Reform*
- Vermont Act 1 (Special Session, approved June 2, 2009 by the legislative override of Governor's veto) entitled, *The Fiscal Year 2010 Appropriations Act*,
- Federal *Children's Health Insurance Program Reauthorization Act* (CHIPRA), and
- Additional technical rule changes initiated by the Department for Children and Families ("the department").

These changes are described more fully below.

I.
Act 61: An Act Related to Health Care Reform

Note: On August 18, 2009, the Joint Fiscal Committee voted to eliminate funding for both of the following provisions of Act 61 as well as repeal of the statutory expansion of eligibility. The Committee also recommended that any decision resulting in eligibility expansion be postponed until after the passage of federal health care reform. The 2010 General Assembly will act on these recommendations. Implementation of the rule is uncertain. The rule is included here because of the statutory obligation to submit this rule. The rule contains language which will preclude implementation of these provisions until after the legislature acts.

Self-employment exception to the waiting period (VHAP Rule 5312(G); Premium Assistance Rule 5901(L)(4))

Section 19 of Act 61 creates an exception for self-employed people who lost their insurance within the past 12 months to enroll in VHAP or premium assistance without waiting 12 months under certain circumstances. Specifically, VHAP and premium assistance programs may be available to self-employed individuals who lost non-group (individual) coverage when their business terminated or the individual became unable to continue in his or her line of work. This change will take effect no sooner than 60 days after the Centers for Medicare and Medicaid Services (CMS) approve an amendment to the Global Commitment for Health Medicaid Section 1115 waiver, and in no event before May 1, 2010.

Depreciation (VHAP Rule 5321(D))

Sections 22(b) and 23 of Act 61 make depreciation an allowable business expense deduction for self-employed individuals who request VHAP or premium assistance coverage. This change is subject to subsequent legislative approval, because the statute requires submission of a cost estimate in January, at which point the legislature will decide upon implementation.

This change will take effect no sooner than 60 days after the Centers for Medicare and Medicaid Services (CMS) approve an amendment to the Global Commitment for Health Medicaid Section 1115 waiver, and in no event before May 1, 2010.

II.
The Fiscal Year 2010 Appropriations Act (Act 1)

Definition of Uninsured (VHAP Rule 5312)

Section E.307.2 of Act 1 authorizes the department to correct a drafting error regarding the VHAP definition of "uninsured." Specifically, individuals who are eligible for Medicare are not eligible for VHAP. This rule has been in place since the inception of the VHAP program; it was inadvertently omitted when amendments (for domestic violence and high deductible health plans) were made to this section last year. This technical correction restores the inadvertently omitted rule text.

III.
The Children's Health Insurance Program Reauthorization Act (CHIPRA)

CHIPRA is a major piece of federal health care legislation that contains a number of eligibility mandates and options for Medicaid and State Children's Health Insurance Program ("SCHIP"). It was passed in February 2009. This bulletin proposes amending Vermont health care rules to implement the following requirements related to citizenship and deeming:

- Medicaid Rule 4170 proposes amendments based on CHIPRA section 211(b)(2). A baby meets the citizenship requirement whenever the birth is covered by Medicaid or SCHIP.

- Medicaid Rule 4171.2 proposes amendments based on CHIPRA section 211(b). A document issued by a federally recognized Indian tribe is considered satisfactory primary evidence of citizenship and identity.

- ANFC-Related Medicaid Rule 4312.8(A) proposes amendments based on CHIPRA section 113(b). A baby is deemed fully Medicaid eligible for the first year of life, when the child has been born to a mother receiving Medicaid. CHIPRA removed the requirement that the baby also had to remain in the mother's household.

IV.
Additional Rule Changes

This bulletin also contains other technical changes as described specifically below:

- Medicaid Rule 4170 – Incorporates exceptions to citizenship and identity requirement previously implemented by Interpretive Memoranda.
- Dr. Dynasaur Rule 5200 - removes this rule series since those rules were incorporated many years ago into the ANFC-Related 4300 rule series related to Children and Families.
- VHAP Rule 5312 – specifies that people whose most recent eligibility was a state-sponsored program are not subject to the 12-month waiting period.
- VHAP Rule 5324 - Incorporates clarification on the meaning of the term caretaker relatives previously implemented by Interpretive Memoranda.
- VHAP Rule 5342.1 – clarifies that when VHAP closes for nonpayment of premium due to medical incapacity, VHAP-Limited coverage will be provided retroactively to the first day of the month that the break in coverage occurred, once the application is received and processed. No premium will be required for the months of medical incapacity at this time due to concerns about jeopardizing federal stimulus money. Also adds loss of health insurance as a result of domestic violence as an exception to

the twelve month waiting period to conform this exception across all applicable programs; adds loss of insurance for self-employed individuals as an exception to the twelve month waiting period.

- Healthy Vermonters Rule 5710 – corrects eligibility from 300 to 350 percent of FPL.
- Healthy Vermonters Rule 5724 – corrects eligibility from 300 to 350 percent of FPL.
- Premium Assistance Rule 5925 – specifies that failure to make a timely premium payment because of medical incapacity is not grounds for retroactive premium assistance coverage. The department is unable to grant medical incapacity exceptions for continuing coverage of premium assistance programs because private carriers can not be forced to back-date coverage.

V.
Specific changes

Program	Rule	Description of change
Medicaid	4170	Adds to list of applicants and beneficiaries not required to document citizenship as a condition of receipt of Medicaid benefits.
Medicaid	4171.2	A document issued by a federally recognized Indian tribe is satisfactory proof of citizenship.
ANFC-Related Medicaid	4312.8	Extends eligibility period for newborns for ANFC-related Medicaid from two months to twelve months after birth. Eliminates requirement that baby live in the same home as mother during that year.
Dr. Dynasaur	5200	Removes this rule series since those rules were incorporated many years ago into the ANFC-Related 4300 rule series related to Children and Families.
VHAP	5312	Clarifies that individuals whose most recent coverage was a state-sponsored program are not subject to the twelve month waiting period for VHAP. Inserts new self-employment exception to the twelve month waiting period. See cautionary language on page 3. Restores language inadvertently omitted that makes Medicare recipients ineligible for VHAP.
VHAP	5321	Allows depreciation as a business expense in calculating eligibility for VHAP. See cautionary language on page 3.
VHAP	5324	Amends income test for VHAP.
VHAP	5342	Amends disenrollment from VHAP due to eligibility for Medicare.
VHAP	5342.1	Provides retroactive coverage of VHAP-Limited in cases of VHAP closure due to lack of payment caused by medical incapacity. Adds domestic violence and loss of insurance by self-employed individuals as exceptions to the twelve month waiting period.

VScript	5620	Clarifies that prescription drug expenses for individuals eligible for or receiving any plan of assistance, including Medicare, Medicaid, or VHAP are not eligible for pharmaceutical assistance under VScript.
HVP	5710	Corrects FPL reference.
HVP	5724	Corrects FPL reference.
Premium Assistance	5901	Amends definition of "uninsured".
Premium Assistance	5925	Specifies that nonpayment of premium because of medical incapacity is not grounds for retroactive coverage of a gap in coverage after reinstatement.

VI.
Rulemaking Process

A. Informal Public Input Process

1. The proposed rule was filed with the Medicaid Advisory Board on November 19, 2009, and presented at its meeting.

2. The proposed rule is expected to be filed with the Interagency Committee on Administrative Rules (ICAR) on December 4, 2009, and presented at its meeting on December 14, 2009.

3. The proposed rule is expected to be filed with the Health Access Oversight Committee as well as the Secretary of State's Office on December 18, 2009. The Office published notice of rulemaking on December 31, 2009 and January 7, 2010.

4. The department will post the proposed rule on its website and notify advocates and members of the public with health care manual rules subscriptions of the proposed rule.

B. Formal Notice and Comment Period

1. A public hearing is scheduled on January 18, 2010 at 1:00 p.m., in the DCF Commissioner's Conference Room, 5 North, State Office Complex, Waterbury, Vermont.

2. Written comments may be submitted no later than 4:30 p.m., on January 25, 2010 to Steve Sease, Health Care Policy Analyst, Economic Services Division, DCF; 103 South Main Street, Waterbury, Vermont 05671-1201 Fax: (802) 241-2235.

3. On February 26, 2010, copies of the final proposed rule are expected to be filed with the Secretary of State and the Legislative Committee on Administrative Rules (LCAR).

4. The department expects to present the rule to LCAR before April 11, 2010.

5. The department expects to file the final rule no later than April 16, 2010.

6. The rule is expected to be effective no sooner than on May 1, 2010.

For information on upcoming hearings before the Legislative Committee on Administrative Rules go to the website of the Vermont Legislature at: http://www.leg.state.vt.us/schedule/schedule2.cfm or call 828-5760.

EXPLANATION OF SYMBOLS

Omission of unchanged parts of a rule are indicated by the insertion of four asterisks separated by spaces (* * * *).

Vertical lines in the left margin indicate changes.

MEDICAID RULES

4170 Citizenship (01/01/2007, 06-48)

A. As a condition of eligibility for Medicaid an individual must be:

1. A citizen or national of the United States (rule 4171), or
2. A qualified alien (rule 4172).

B. Exceptions: Certain qualified aliens are barred from Medicaid for five years. (rule 4173).

C. Qualified aliens affected by the five-year bar and non-qualified aliens may be eligible for emergency services and/or emergency labor and delivery services. (rule 4177).

D. Except as provided in paragraph (E) of this section, Medicaid applicants and beneficiaries must:

1. Sign a declaration that the individual is a citizen or national of the United States (rule 4171) or a qualified alien (rule 4172), and
2. Provide documentation of citizenship or immigration status and identity (rules 4171.1 and 4171.2).

E. The following individuals are not required to document citizenship and identity as a condition of receipt of Medicaid benefits:

1. Those who have received either Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), or Medicare.
2. Children in IV-E foster care.
3. Children receiving Title IV-E adoption assistance.
4. Children born in the United States on or after April 1, 2009 when the child's mother is covered by state administered health care assistance under Title XIX or XXI, other than premium assistance, at the time of birth.

4171.2 Citizenship and Identity Documentation (01/01/2007, 06-48)

* * * *

C. Primary Evidence of Citizenship and Identity

1. The following evidence will be accepted as satisfactory documentary evidence of both identity and citizenship:

a. A U.S. Passport

The Department of State issues this. A U.S. passport need not be currently valid to be accepted as evidence of U.S. citizenship, as long as it was originally issued without

limitation. However, a passport that was issued with limitation and is not currently valid may be used as proof of identity.

i. U.S. passports issued after 1980 show only one person. However, spouses and children were sometimes included on one passport through 1980. Consequently, the citizenship and identity of the included person can be established when one of these passports is presented.

b. A Certificate of Naturalization (DHS Forms N-550 or N-570)

Department of Homeland Security issues this.

c. A Certificate of U.S. Citizenship (DHS Forms N-560 or N-561)

Department of Homeland Security issues certificates of citizenship to individuals who derive citizenship through a parent.

d. An Indian Tribe Document

A document issued by a federally recognized Indian tribe evidencing membership or enrollment, or affiliation with, such tribe (such as a tribal enrollment card or certificate of Indian blood.) The Secretary of Health and Human Services will issue regulations concerning tribes located in states with international borders whose members include individuals who are not citizens of the United States. The regulations will authorize the presentation of such other forms of identification that the Secretary determines to be satisfactory evidence of citizenship or nationality.

2. Individuals born outside the U.S. who were not citizens at birth must submit primary evidence of U.S. citizenship and identity. However, children born outside the United States and adopted by U.S. citizens may establish citizenship using the process established by the Child Citizenship Act of 2000 (Pub. L. 106-395, enacted on October 30, 2000). (rule 4171(c)).

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ANFC-RELATED MEDICAID RULES

4312.8 Other Eligible Family Members (07/01/2001, 01-16)

A. (Newborns) A child born to a woman eligible for and receiving state administered health care assistance, other than premium assistance, on the date of the child's birth is eligible for ANFC-related Medicaid. The child is deemed eligible for twelve months after birth.

B. (Adoption or Foster Care) Children under the age of 21 living in Vermont for whom an adoption assistance agreement is in effect or foster care maintenance payments are being made (by any state) under title IV-E of the Act are automatically eligible for ANFC-related Medicaid. Committed children in the custody of the Family Services Division not IV-E eligible must pass the applicable eligibility tests before their eligibility for Medicaid can be established.

C. (Special Needs Adoption) Children under the age of 21 with special needs for medical or rehabilitative care at the time of adoption who were eligible for Medicaid prior to the adoption assistance agreement other than an agreement under title IV-E are automatically eligible for ANFC-related Medicaid.

D. (Hospice Care) Individuals who would be eligible for Medicaid under the plan if they were in a medical institution (i.e., their income is under the institutional income standard and they meet all other eligibility tests), who are terminally ill, and who receive hospice care in accordance with a voluntary election described in section 1905(o) of the Act.

E. (Breast or Cervical Cancer) Women who have been screened for and found to have breast or cervical cancer, including precancerous conditions, through the National Breast and Cervical Cancer Early Detection Program (NBCCEDP); are under age 65; and are uninsured and otherwise not eligible for SSI-related or ANFC-related Medicaid. Coverage under this category begins following the screening and diagnosis and continues for as long as a treating health professional verifies the woman is in need of cancer treatment services.

Dr. Dynasaur Rules

5200-
5255

VHAP RULES

5312 Uninsured (12/04/2008, 08-40)

Individuals are considered "uninsured" and meet this requirement if they are not eligible for Medicare and have no other insurance that includes both hospital and physician services, and did not have such insurance within the 12 months prior to the month of application, unless they meet one of the exceptions specified below.

A. An individual with household income, after allowable deductions, at or below 75 percent of the federal poverty guideline for households of the same size;

B. An individual who lost private insurance or employer-sponsored coverage during the prior 12 months for the following reasons:

1. The individual's coverage ended because of:

a. Loss of employment, including a reduction in hours that results in ineligibility for employer-sponsored coverage, unless the employer has terminated its employees or reduced their coverage for the primary purpose of discontinuing employer-sponsored coverage and establishing their eligibility for Catamount Health;

b. of the principal insurance policyholder;

c. Divorce of dissolution of a civil union;

d. No longer receiving coverage as a dependent under the plan of a parent or caretaker relative; or

e. No longer receiving COBRA, VIPER, or other state continuation coverage; or

2. College- or university-sponsored health insurance became unavailable to the individual because the individual graduated, took a leave of absence, decreased enrollment below a threshold set for continued coverage, or otherwise terminated studies. However, students under the age of 23 enrolled in a program of an institution of higher education are not eligible for coverage, if they:

a. Have elected not to purchase health insurance covering both hospital and physician services offered by their educational institution; or

b. Are eligible for coverage through the policy held by their parents, but their parents have elected not to purchase this coverage.

D. The individual lost health insurance as a result of domestic violence. The individual shall provide the agency of human services with satisfactory documentation of the domestic violence. The documentation may include a sworn statement from the individual attesting to the abuse, law enforcement or court records, or other documentation from an attorney or legal advisor, member of the clergy, or health care provider, as defined in section 9402 of Title 18. Information relating to the domestic violence, including the individual's statement and corroborating evidence, provided to the agency shall not be disclosed by the agency unless the individual has signed a consent to disclose form. In the event the agency is legally required to release this information without consent of the individual, the agency shall notify the individual at the time the notice or request for release of information is received by the agency and prior to releasing the requested information.

NOTE: This subdivision shall take effect upon issuance by the Centers for Medicare and Medicaid Services of approval of an amendment to the Global Commitment for Health Medicaid Section 1115 Waiver allowing for a domestic violence exception to the Catamount Health premium assistance waiting period.

E. Notwithstanding any other provision of law, when an individual is enrolled in Catamount Health solely under the high deductible standard outlined in 8 V.S.A. § 4080f(a)(9), the individual shall not be eligible for the Vermont health access plan for the 12-month period following the date of enrollment in Catamount Health.

F. Prior Enrollment in a Health-Care Program

No waiting period is imposed because of the loss of:

1. Medicaid;
2. VHAP;
3. Dr. Dynasaur;
4. VHAP-ESIA;
5. Catamount-ESIA;
6. Catamount Health with or without premium assistance, or
7. Prior state administered coverage under Title XIX or Title XXI of the Social Security Act by another public entity.

G. A self-employed individual insured through the nongroup market who lost insurance as the direct result of either:

1. the termination of a business entity owned by the individual
   or
2. the individual's inability to continue in his or her line of work, if:
   - the individual produces satisfactory evidence of the business termination or
   - certifies by affidavit that he or she is not employed and is no longer seeking employment in the same line of work.

NOTE: Subsection G. shall take effect no sooner than 60 days following approval by the Centers for Medicare and Medicaid Services, and in no event before May 1, 2010.

The Joint Fiscal Committee, on August 18, 2009, voted to eliminate funding for this provision. The Committee also recommends repeal of statutory authorization for this provision in the 2010 Adjourned Session. Implementation of the rule is uncertain.

5321 <u>Income</u> (05/15/1996, 96-18)

Countable income is all earned and unearned income, as defined in this section, less all allowed deductions.

* * * *

D. <u>Business Expenses</u>

Business expenses, which are deducted from gross receipts to determine adjusted gross earned income, are limited to operating costs necessary to produce cash receipts, such as:

1. Office or shop rental; taxes on farm or business property;

2. Hired help;

3. Interest on business loans;

4. Cost of materials, stock, and inventory, livestock for resale required for the production of this income; and

5. Depreciation.

Items such as personal business and entertainment expenses, personal transportation, purchase of capital equipment and payment on the principal of loans for capital assets or durable goods are not allowable business expenses.

NOTE: Changes to section D. 5 shall take effect no sooner than 60 days following approval by the Centers for Medicare and Medicaid Services but in no event before May 1, 2010. The legislature must also review results of a study of estimated costs before implementation. The Joint Fiscal Committee, on August 18, 2009, voted to eliminate funding for this provision. The Committee recommends repeal of statutory authorization for this provision in the 2010 Adjourned Session. Implementation of the rule is uncertain.

Tax returns and business records are considered appropriate sources of accurate figures for farm and business receipts and expenses.

The income of a VHAP group owning or operating a commercial boarding house shall be treated as any other business income. A commercial boarding house is defined as an establishment licensed as a commercial enterprise that offers meals and lodging for compensation. In areas without licensing requirements, a commercial boarding house shall be defined as a commercial establishment that offers meals and lodging with the intention of making a profit.

No computation is required for foster homes furnishing boarding care to children in custody of, and placed by, the Family Services Division (FSD). Department board rates are established to cover expenses only, with no profit available; therefore, no earned income is considered available from this source.

For a VHAP group that is not a commercial boarding house, the business expense of furnishing room and board, alone or as part of custodial care, shall be allowed, provided that the amount shall not exceed the payment the VHAP group receives from the roomer/boarder for lodging/meals. (See the Medicaid Procedures Manual at P-2420 D2 for the table of standard business expense deductions for homes providing room or board on a non-commercial basis.)

* * * *

5324 <u>Income Test</u> (07/01/2001, 01-07)

Individuals with group income less than 150 percent of the federal poverty level (FPL) are eligible for VHAP, as long as none of the conditions that result in a reduced income test apply. These conditions are described in paragraph three below.

Uninsured parents and caretaker relatives having dependent children in their households and group income less than 185 percent of the federal poverty level (FPL) are eligible for VHAP. This higher income test applies to those caring for children. If the household includes two caretaker relatives, the 185% income test applies to both adults.

Current poverty levels are at P-2420.

The income maximums (P-2420) are updated annually on January 1 using a methodology similar to the one employed by the federal government in setting the FPLs. In years when the actual FPL exceeds ESD's income maximum, ESD will issue a second increase on April 1.

5342 Eligibility Period and Enrollment (12/01/2003, 03-17)

A. Eligibility

The VHAP eligibility criteria are described in rules 5311 – 5331.

B. Enrollment

If all eligibility criteria are met, the individual shall be enrolled in the VHAP program on the first day of the month after the department has received and processed the premium.

Once enrolled, coverage continues until the scheduled eligibility review unless beneficiaries are disenrolled from the program following a notice mailed at least 11 days before the termination date because they:

1. have a change in income that results in income over the applicable income test;

2. have a change in the household size that results in income over the income test for the new household size;

3. lose eligibility as a student;

4. are incarcerated;

5. are admitted to a long-term care facility, such as a nursing home, a free-standing psychiatric facility or an ICF/MR facility for longer than 30 days;

6. acquire insurance that includes both hospital and physician coverage that has no disqualification period for a pre-existing condition, or has a disqualification period that has ended or that has lasted for one year or more;

7. become eligible for Medicare coverage regardless of enrollment;

8. move out-of-state;

9. voluntarily disenroll from the program;

10. are found to have been ineligible on the date coverage began;

11. are no longer in contact with the department and have no known address;

12. fail to provide verification requested for another program if it pertains to an eligibility factor for the VHAP program;

13. fail to pay any required premiums; or

14. die.

The notice will inform beneficiaries of their appeal rights and provide them with information about other health care assistance, including how and where to apply.

Individuals are required to report any of the above changes, as applicable, and any change of address within 10 days of the change.

Individuals who have been disenrolled from the VHAP program must file a new application for the program before eligibility may be re-established.

A review of eligibility will be completed before the end of each certification period to assure uninterrupted coverage if the individual remains eligible, complies in a timely manner with review requirements, and pays any required premium by the due date. An individual who fails to comply timely with review requirements and paying any required premium shall receive a termination notice mailed at least 11 days before the termination date. A failure to comply timely may result in a gap in coverage.

5342.1 VHAP-Limited Coverage (10/01/2007, 07-24)

Individuals applying for VHAP will receive limited coverage, as described in the Medicaid Procedures Manual section P-4003, at no cost between the date the department determines eligibility and the date full coverage begins. Full coverage begins on the first day of the month after the department has processed the full premium payment as specified at rules 4160-4162. Individuals who do not pay the full premium by the due date are responsible for all bills incurred during that limited coverage period. The notice of eligibility the department sends individuals describes the limited coverage and includes a warning that failure to pay the full premium by the due date will result in no coverage for any bills incurred since the date of eligibility. Individuals will also be notified of the requirement that they must choose a primary care provider by the premium due date, or one will be chosen for them by the department.

When an individual's eligibility or coverage is cancelled or closed in whole or in part due to nonpayment of the premium and the individual attempts to reenroll within twelve months, VHAP-Limited coverage will be provided only if the individual meets one of the five exceptions listed below.

A. The individual or spouse had employer-sponsored insurance that terminated because of:

1. loss of employment;

2. death of the principal insurance policyholder;

3. divorce or dissolution of a civil union;

4. no longer qualifying as a dependent under the plan of a parent or caretaker relative; or

5. no longer receiving COBRA, VIPER or other state continuation coverage.

B. The individual or spouse had university-sponsored insurance that terminated because they graduated, took a leave of absence, or otherwise terminated their studies. Students under the age of 23 enrolled in a program of an institution of higher education are not eligible for coverage, however, if they:

1. have elected not to purchase health insurance covering both hospital and physician services offered by their educational institution; or

2. are eligible for coverage through the policy held by their parents, but their parents have elected not to purchase this coverage.

C. The individuals household income dropped below 75% of FPL, after allowable deductions, for households of the same size.

D. The individual established residence in another state for more than 30 days and subsequently returned to Vermont.

E. The individual was medically incapacitated, as specified in rule 4161, during the period when premium payments were due. In cases of medical incapacity, VHAP-Limited coverage will be provided as of the first day of the month following the month of closure due to non payment of premium because of medical incapacity, once the application has been received and processed. No premium will be required for the period of medical incapacity.

If the health condition related to this medical incapacity is expected to continue or recur, the department will encourage beneficiaries to designate an authorized representative to receive and pay future bills for as long as the anticipated duration of the condition.

F. The individual lost health insurance as a result of domestic violence. The individual shall provide the agency of human services with satisfactory documentation of the domestic violence. The documentation may include a sworn statement from the individual attesting to the abuse, law enforcement or court records, or other documentation from an attorney or legal advisor, member of the clergy, or health care provider, as defined in section 9402 of Title 18.

Information relating to the domestic violence, including the individual's statement and corroborating evidence, provided to the agency shall not be disclosed by the agency unless the individual has signed a consent to disclose form. In the event the agency is legally required to release this information without consent of the individual, the agency shall notify the individual at the time the notice or request for release of information is received by the agency and prior to releasing the requested information.

G. A self-employed individual insured through the nongroup market who lost insurance as the direct result of either:

1. the termination of a business entity owned by the individual

or

2. the individual's inability to continue in his or her line of work, if:

   - the individual produces satisfactory evidence of the business termination or
   - certifies by affidavit that he or she is not employed and is no longer seeking employment in the same line of work.

NOTE: Subsection G shall take effect no sooner than 60 days following approval by the Centers for Medicare and Medicaid Services, but in no event before May 1, 2010.

The Joint Fiscal Committee, on August 18, 2009, voted to eliminate funding for this provision. The Committee also recommends repeal of statutory authorization for this provision by the 2010 Adjourned Session. Implementation of the rule is uncertain.

VSCRIPT RULES

5620 Uninsured Definition (01/01/2006, 05-24)

An individual whose prescription drug expenses are paid or reimbursable, either in whole or in part, by any plan of assistance or insurance, including Medicaid, Medicare or VHAP, or eligibility for Medicaid, Medicare or VHAP, shall not be eligible for pharmaceutical assistance under VScript.

HEALTHY VERMONTERS RULES

5710 Eligibility (01/01/2006, 05-24)

Individuals are eligible for Healthy Vermonters if they have household income no greater than 300 percent of the federal poverty level (FPL), as calculated under the rules for the VHAP program.

Individuals are also eligible for Healthy Vermonters if they have household income no greater than 400 percent of the FPL, as calculated under the rules for the VHAP program (5300), and meet the categorical eligibility requirements.

The following table presents the eligibility requirements.

Eligibility Requirements for Healthy Vermonters

Income Maximum	Categorical Eligibility Requirement
350 Percent of the FPL	None
400 percent of the FPL	Age 65 or older
	Or disabled
	Or disabled and eligible for social security disability benefits

Individuals remain eligible as long as they meet all program requirements.

5724 Income Test (01/01/2006, 05-24)

Individuals are eligible for Healthy Vermonters if they have income no greater than 350 percent of the federal poverty level (FPL).

Individuals are also eligible for Healthy Vermonters if they have income no greater than 400 percent of the FPL and are: 65 or older; or disabled and eligible for social security disability benefits.

The income guidelines are updated annually on January 1 using a methodology similar to the one employed by the federal government in setting the FPLs. In years when the actual FPL exceeds ESD's income maximum, ESD will issue a second increase on April 1.

PREMIUM ASSISTANCE RULES

5901 Definitions (12/04/2008, 08-40)

* * * *

L. Uninsured. An individual who does not qualify for Medicare, Medicaid, VHAP, or Dr. Dynasaur and had no private insurance or employer-sponsored coverage that includes both hospital and physician services within twelve months prior to the month of application, or lost private insurance or employer-sponsored coverage during the prior twelve months for any of the following reasons:

1. The individual's private insurance or employer-sponsored coverage ended because of:

   a. Loss of employment, including a reduction in hours that results in ineligibility for employer-sponsored coverage, unless the employer has terminated its employees or reduced their hours for the primary purpose of discontinuing employer-sponsored coverage and establishing their eligibility for CH

   b. Death of the principal insurance policy holder;

   c. Divorce or dissolution of a civil union;

   d. No longer qualifying as a dependent under the plan of a parent or caretaker relative;

   e. No longer receiving COBRA, VIPER, or other state continuation coverage; or

2. College- or university-sponsored health insurance became unavailable to the individual because the individual graduated, took a leave of absence, decreased enrollment below a threshold set for continued coverage, or otherwise terminated studies.

3. The individual lost health insurance as a result of domestic violence.

   a. The individual shall provide the agency of human services with satisfactory documentation of the domestic violence. The documentation may include a sworn statement from the individual attesting to the abuse, law enforcement or court records, or other documentation from an attorney or legal advisor, member of the clergy, or health care provider, as defined in section 9402 of Title 18. Information relating to the domestic violence, including the individual's statement and corroborating evidence, provided to the agency shall not be disclosed by the agency unless the individual has signed a consent to disclose form. In the event the agency is legally required to release this information without consent of the individual, the agency shall notify the individual at the time the notice or request for release of information is received by the agency and prior to releasing the requested information.

b. Subdivision (a) of this subdivision (3) shall take effect upon issuance by the Centers for Medicare and Medicaid Services of approval of an amendment to the Global Commitment for Health Medicaid Section 1115 Waiver allowing for a domestic violence exception to the Catamount Health premium assistance waiting period.

4. A self-employed individual insured through the nongroup market who lost insurance as the direct result of either:

a. the termination of a business entity owned by the individual; or

b. the individual's inability to continue in his or her line of work when the individual produces satisfactory evidence to the Department for Children and Families Economic Services Division (ESD) of the business termination. Satisfactory evidence may include an affidavit to the ESD that the individual is not employed and is no longer seeking employment in the same line of work.

NOTE: Subsection 4 shall take effect no sooner than 60 days following approval by the Centers for Medicare and Medicaid Services, but in no event before May 1, 2010..

The Joint Fiscal Committee, on August 18, 2009, voted to eliminate funding for this provision. The Committee also recommends repeal of statutory authorization for this provision by the 2010 Adjourned Session. Implementation of the rule is uncertain.

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5925 <u>Eligibility Period and Enrollment</u> (10/01/2007, 07-24)

Eligibility for all premium-assistance programs is subject to annual review. Eligibility review will be completed before the end of each certification period to assure uninterrupted coverage if the individual remains eligible, complies in a timely manner with review requirements, and pays any required premium by the due date. An individual who fails to timely comply with review and premium requirements shall receive a termination notice mailed at least eleven days before the termination date. A failure to timely comply may result in a gap in coverage. If a beneficiary's coverage is terminated because of nonpayment of the premium, and the reason for nonpayment is medical incapacity, reinstatement is unavailable for the gap.